PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Created by:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

State of Michigan

NOTE: This application template is pending approval from the Office of Management and Budget and is considered draft.

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Table of Contents

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Pharmacy Plus Application

The State of _Michigan__, Department of __Community Health__ proposes an 1115 demonstration Proposal entitled EPIC Ex_, which will extend pharmacy services and related medical management interventions to _aged _ individuals with income below _200_ percent of the Federal poverty level (FPL).

I. GENERAL DESCRIPTION

This demonstration will extend pharmacy coverage, via authority under section 1115 of the Social Security Act (the Act), to individuals in a fashion that furthers public, private, and individual fiscal responsibility. The demonstration is designed to increase the extent of pharmacy coverage in the state by assisting low-income Medicare beneficiaries who are age 65 or older. The demonstration offers assistance by 1) providing access to prescription drugs and related services, 2) assisting individuals with high premiums/cost sharing for private coverage for prescription drugs, or 3) providing wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of the Pharmacy Plus benefit coverage. The proposed program also ensures access to primary care to complement and assist in the management of the enrollee's pharmacy services. An important element in Pharmacy Plus is the use of competitive private sector approaches, such as benefit management, to provide more cost effective, modern prescription drug benefits in Medicaid

Individuals eligible for the proposed program include those who are Medicare beneficiaries, who have not been determined eligible for traditional Medicaid benefits, whether or not they are eligible for Medicare Savings programs under Medicaid (which pay Medicare premiums, and in some cases, Medicare cost sharing expenses, e.g., QMBs and SLMBs) and/or people with a disability. Cost sharing - in the form of premiums, copayments, coinsurance, and deductibles - for the expansion population may differ from cost-sharing requirements for the regular Medicaid program.

The budget neutrality ceiling will be a single aggregate budget amount for the demonstration period. The state will be accountable for both expenditure and enrollment growth in the population subject to the budget neutrality ceiling which includes both the demonstration enrollees and the budget neutrality impacted population. The demonstration impacted population is that current law Medicaid eligibility group whose costs will be captured in order to measure budget neutrality.

The demonstration will operate for _5__ years, beginning approximately _July 1, 2003_.

II. ASSURANCES

Each of the following items are checked to indicate an assurance:

A. __X__ **Primary care coordination**. The demonstration includes a mechanism to direct demonstration enrollees who access services to sources of primary health services. Such primary care will include, but is not limited to, medical management related to prescription and non-prescription pharmaceutical products. The state assures that those individuals who do not have access to primary care as Medicare beneficiaries will have access to primary care services. More information about this requirement is provided in Section V, Part I.

B. __X__ **Benefits, access to services, and cost sharing.** The benefits and rights of the state plan eligibility groups, except for restriction to choice of providers as provided through a section 1115(a)(1) waiver of section 1902(a)(23) of the Act through Pharmacy Plus, are as provided for in the state's Medicaid state plan, Title 42 of the Code of Federal Regulations, and Title XIX of the Social Security Act.

C. __X__ **Budget neutrality.** The Federal cost of services provided during the demonstration will be no more than 100 percent of the expected Federal cost to provide Medicaid services under current law without the demonstration. The benefits and rights of the state plan eligibility groups are not altered by this demonstration. An Excel budget worksheet is provided that includes the budget projections, with and without waiver cost estimates, information about covered individuals, trend rate information, and a narrative description of the calculations. More information about this requirement is provided in Section VI.

D. __X__ **Public notice requirements**. The demonstration complies with public notice requirements as published in the Federal Register, Vol. 59, No. 186 dated September 29, 1994 (Document number 94-23960) and Centers for Medicare & Medicaid Service (CMS) requirements regarding Native American Tribe consultation. Provide information about this assurance in Appendix 1.

III. STATE-ONLY FUNDED PHARMACY PROGRAMS

The following information is provided for current state-only funded pharmacy programs (Check all that apply):

A. _X_ **State program entirely subsumed into demonstration.** A state-only funded pharmacy program named _Elder Prescription Insurance Coverage (EPIC) program_ currently exists, and it will be subsumed by the demonstration (Complete this section for each state program that will be entirely subsumed into the demonstration program. Provide as an attachment a description of the state-only funded program, including enrollee cost-sharing, benefit limits, wraparound coverage, and any other pertinent features).

1. Income level ceiling. The income level ceiling for participation is__200_ percent of the Federal poverty level (FPL).

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
   a. __X__ age group (describe): **Participants must be age 65 or older.**
   c. _____ condition specifications (describe):
   d. _ X__ other specifications (describe): **Participants must be non-institutionalized, have no prescription drug coverage except for Medicare supplemental policies (including Medicare+Choice coverage), be a permanent Michigan resident, have been a resident for at least 90 days and not be enrolled in the Medicaid program with full coverage.**

3. Benefit coverage scope. The scope of benefits covered under the program is:
   a. __X__ broad (such as the Medicaid package):
   b. _____ narrow (such as limited to drugs to treat specific health conditions):
   c. _____ other (describe):

4. __X__ There are enrollee financial contributions, which include:
   a. _____ premiums (describe):
   b. _____ deductibles (describe):
   c. _ X _ copayments/coinsurance (describe): **The EPIC program has a sliding scale co-payment schedule based on total annual household income. At enrollment, each enrollee is assigned a monthly maximum out of pocket co-payment. The enrollee is then assessed a co-payment amount of 20% until the monthly maximum is met. No enrollee can be charged more that 20% of the cost of a single prescription unless a brand name drug is purchased when a generic equivalent is available. In this case, the EPIC statute requires that an additional $15 co-payment be assessed. These additional co-payments do not count toward a beneficiary's monthly cap. Unused co-payment obligations carry forward to the next month until the end of the benefit year. (The co-payment aggregates to a benefit year obligation.) The monthly maximum out of pocket co-payment structure is as follows:**

Annual Household Income as a Percentage of Federal Poverty Level	Monthly Out-of-Pocket Maximum
100% and below	1/12th of one percent of annual household income
101% to 125%	1/12th of two percent of annual household income
126% to 150%	1/12th of three percent of annual household income
151% to 175%	1/12th of four percent of annual household income
176-200%	1/12th of five percent of annual household income

d. _ X__ other (describe): **All applicants must pay an annual non-refundable $25 application-processing fee that is required by the statute that created the EPIC program.**

5. This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:
   a. _____ expanding the scope of coverage (e.g., type or number of prescriptions available) (describe):
   b. _____ expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)(describe):
   c. _____ expanding the type of individuals eligible (describe estimates):
   d. _ X__ expanding the number of individuals eligible (describe estimates**): The existing state program provides coverage to approximately 15,000 participants. This Pharmacy Plus waiver will make it possible to boost enrollment up to as many as 42,000 individuals during any given month.**
   e. ____ expanding funding to assist with premiums and cost sharing (describe):
   f, ____ other (describe):

6. Annual cost. Currently the program expenditures are $_27.4 million_ on an annual basis for the program.

7. Enrollment figures. Currently there are _15,000_ enrollees in the program.

8. Average cost per enrollee/per month is $ _152_.

B. ____ State program partially subsumed into demonstration. A state-only funded pharmacy program named _____ currently exists, and will be **partially** subsumed by the demonstration (Complete this section for each state program that will be partially subsumed into the demonstration program. Provide as an attachment a description of the state-only funded program, including enrollee cost-sharing, benefit limits, wraparound coverage, and any other pertinent features).

1. Income level ceiling. The income level ceiling for participation is_____ percent FPL.

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
    a. _____ age group (describe):
    b. _____ condition specifications (describe):
    c. _____ other specifications (describe):

3. Benefit coverage scope. The scope of benefits covered under the program is:
    a. _____ broad (such as the Medicaid package);
    b. _____ narrow (such as limited to drugs to treat specific health conditions);
    c. _____ other (describe):

4. _____ There are enrollee financial contributions, which include:
    a. _____ premiums (describe):
    b. _____ deductibles (describe):
    c. _____ copayments/coinsurance (describe):
    d. _____ other (describe):

5. This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:

    a. _____ expanding the scope of coverage (e.g., type or number of prescriptions available) (describe):
    b. _____ expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)(describe):
    c. _____expanding the type of individuals eligible (describe estimates):
    d. _____expanding the number of individuals eligible (describe estimates):
    e. _____expanding funding to assist with premiums and cost sharing (describe):
    f. _____other (describe):

6. Annual cost. Currently the program expenditures are $_____ on an annual basis for the program.

7. Enrollment figures. Currently there are _____ enrollees in the program.

8. Average cost per enrollee/per month is $ _____.

C. _____ **State program not subsumed by demonstration.** A state-only funded pharmacy program(s) named _____ currently exists, will not be subsumed by the demonstration, and will continue to operate during the Pharmacy Plus demonstration operation.

D. _____ **No state funded pharmacy program currently exists.** A state-only funded pharmacy program does not exist in this state.

IV. PROGRAM ELEMENTS

Population to Whom Eligibility is Expanded under this Demonstration

Individuals eligible for Pharmacy Plus include Medicare beneficiaries who are age 65 or older or who have a disability, whether or not they are eligible for Medicare Savings programs under Medicaid (which pay Medicare premiums, and in some cases, Medicare cost sharing expenses, e.g., QMBs and SLMBs) and/or people with a disability, who have not been determined eligible for full Medicaid benefits. States also may propose to extend the pharmacy benefit to persons age 65 and older who are not Medicare beneficiaries and to persons under age 65 who receive Social Security Disability Insurance (SSDI) but not Medicare (i.e., are in the 24-month waiting period for Medicare) or who have a disability as defined by the Supplemental Security Income (SSI) program.

A. Eligibility groups

1. __X__ Aged individuals (65 and older)
   a. __X__ Medicare beneficiaries
   b. __X__ non-Medicare beneficiaries
   c. __X__ individuals with private pharmacy coverage (describe): **The demonstration will include individuals with Medicare supplemental insurance and/or Medicare+Choice. Statute requires that the existing state program include individuals that have Medicare supplemental coverage. EPIC Ex is payer of last resort, except for services provided through the Indian Health Service.**
   d. _____ other (describe):

2. ____ Individuals with Disabilities (ages ____ to ____)
   a. _____ Medicare beneficiaries
   b. _____ individuals with private pharmacy coverage (describe):
   c. _____ SSDI beneficiaries in 24-month waiting period for Medicare
   d. _____ lost SSDI due to earnings (disabling condition continues)
   e. _____ could receive Supplemental Security Income if Federal eligibility rules used (for 209(b) states)
   f. _____ other (describe):

3. _____ Other (describe):

B. Income groups

1. _200_ percent of FPL is the ceiling for the demonstration expansion group for aged individuals. NOTE, the CMS proposed ceiling is 200 percent FPL or below. The current Medicaid state plan coverage percentage level for this group is 100_ percent FPL (if group varies within the aged population, describe): **This is the percentage of the FPL that qualifies individuals in the 65 years of age and older age group for the Aged and Disabled (AD Care) program.**

2. _____ percent of FPL is the ceiling for the demonstration expansion group for individuals with disabilities. NOTE, the CMS proposed ceiling is 200 percent FPL or below. The current Medicaid state plan coverage percentage level for this group is ____ percent FPL (if group varies within the disabled population, describe):

C. Income adjustments

1. _____ Income is adjusted
   a. _____ in the same manner as in Medicaid for the _____ group
   b. _____ in a different manner than in Medicaid (describe):
2. __X__ income is not adjusted

D. Assets test (an assets test of some level is recommended)

1. _____ an assets test will apply. It is
   a. _____ the same as the Medicaid assets test for the _____ group
   b. _____ different from the Medicaid assets test (describe):
2. __X__ no assets test will apply

E. Enrollment limit

1. _42,000_ is the total number of enrollees permitted to enroll in the demonstration (describe how and why this number was chosen): The state should clarify whether enrollment limits are year-specific or if the enrollment limit is the maximum enrollment for the five years. (For example, the state intends that 50,000 will enroll and the cap starts whenever 50,000 people enroll; or the state intends that 50,000 will enroll in Year One, 55,000 in Year Two, 60,000 in Year Three, etc.). **The state will cap enrollment for any given month at not more than 42,000 beneficiaries. It should be clearly understood that this is a rolling, point-in-time cap vs. a cumulative cap on unduplicated persons participating in the program. This number is based on the anticipated amount of state funding that will be available to serve as match. The number enrolled for each of the five demonstration years will depend on demand, the availability of state matching funds and compliance with federal budget neutrality. Overall, funding limitations will be the principle factor controlling enrollment. Demand is expected to exceed capacity. Therefore, enrollment will occur on a first come, first serve basis with priority assigned to persons with income below 150% of the federal poverty level.**
2. _____ There will not be an enrollment ceiling
3. _____ The state will not utilize an enrollment ceiling initially, but will track budget neutrality and plans to utilize the enrollment ceiling at a later point in time (describe):

F. Pharmacy benefits package

Consistent with the pharmaceutical focus of Pharmacy Plus, the demonstration does **not** include

non-pharmacy benefit changes (such as reducing Medicaid coverage for other services or reducing coverage for existing Medicaid populations). The challenge posed in Pharmacy Plus is to improve cost-effectiveness through maintaining the health status of individuals and managing medications more effectively. The drug rebate provisions of section 1927 of the Act are triggered by state payments for prescription drugs under the plan by operation of the Pharmacy Plus demonstration project, and thus, rebates may be collected from manufacturers for drugs provided to the expansion population. The Federal share of rebates paid will be returned to the Federal government.

The following describes the proposed benefits to be included in this demonstration (check all that apply):

1. __X__ demonstration eligibility will be extended to those who have pharmacy coverage through private health insurance, and enrollees will receive:
   a. _____ assistance with private health insurance cost sharing (see Section V.H.);
   b. __X__ wraparound services (See Section V.H.); **Limited to individuals with a limited pharmacy benefit through Medicare supplemental insurance.**
   c. _____ other (describe and See Section V.H.):

2. __X__ enrollees without private health insurance pharmacy coverage will receive prescription drug coverage as follows:
   a. __ __ the benefit package will be the same as in the Medicaid state plan for non-demonstration enrollees;
   b. __X__ the benefit package will differ from that in the Medicaid state plan for non-demonstration enrollees in that:
      i. __X__ certain classes of drugs will be excluded or limited (describe**): Coverage is restricted to most oral medications currently covered by Medicaid. Insulin and syringes are also covered.**
      ii. _____ the number or frequency of prescriptions covered will be less than in the Medicaid state plan for non-demonstration enrollees (describe):
      iii. _____ drugs covered only for specified conditions (describe):
      iv. _____ other (describe):
   c. _____ other (describe):

3. the state limits benefits to a financial ceiling per _____ of $ _____ (describe):

4. _____ other (describe):

G. Pharmacy benefit management

Pharmacy Plus programs may use private-sector benefit management approaches consistent with the requirements of section 1927(d) of the Act (such as pharmacy benefit managers, preferred drug lists, prior authorization, pharmacist consultation, provider education, disease state management, and variable enrollee cost sharing) in order to more efficiently and effectively manage pharmaceutical costs and ensure that spending stays within the Federal budget neutrality

cap. In accordance with Section 1927 of the Act, these benefit management approaches also may be extended to some or all of the existing Medicaid population, and the resulting savings used to assist in achieving budget neutrality. The demonstration will include pharmacy benefit management as follows:

1. __X__ pharmacy benefit manager (describe):
   a. __ X_ this is currently used in the state Medicaid program, will continue to be operated similarly, and it is currently under contract with _First Health Services Corporation_;
   b. ____ this is not used in the state Medicaid program and will be used only for demonstration enrollees;
   c. ____this will be introduced with the demonstration and will apply to both the demonstration and non-demonstration Medicaid population;
   d. ____ other (describe):

2. __X__ prior authorization consistent with Section 1927(d)(5) of the Act (describe) **Michigan currently employs an expanded prior authorization process using the services of a pharmacy benefit manager. Expanded prior authorization requirements have been implemented for about 40 drug classes in order to maintain clinical efficacy and to improve health outcomes and patient quality of life while addressing the high cost of providing pharmaceutical products. Using a clinically based model, the state Pharmacy and Therapeutics committee selected the drugs that are considered best in these classes. These drugs, as well as those that fall within the reference price and for which the state has negotiated a supplemental rebate, are placed on the preferred drug list. Drugs that are not included on the preferred list require prior authorization with medical justification of necessity.**
   a. __X__ this is currently used in the state Medicaid program;
   b. _____ this is not used in the state Medicaid program and will be used only for demonstration enrollees;
   c. _____ this will be introduced as a state plan amendment with the demonstration and will apply to both the demonstration and non-demonstration Medicaid population

3. __ __formulary or formulary exclusions consistent with Section 1927(d)(4) of the Social Security Act (describe):
   a. __ __this is currently used in the state Medicaid program;
   b. _____this is not used in the Medicaid program and will be used only for demonstration enrollees;
   c. _____this will be introduced as a state plan amendment with the demonstration and will apply to both the demonstration and non-demonstration Medicaid population;
   d. _____ other (describe):

H. Coordination with other sources of pharmacy coverage – private, state, and Medicare Plus Choice plans

Coordination with and non-duplication of existing sources of health insurance is an important feature of the Pharmacy Plus Demonstration. It maintains the position of Medicaid as payer of last resort and provides an incentive for enrollees to continue to participate in private coverage, thus supporting the maximization of participation in private insurance, employer sponsored insurance, COBRA, retiree health insurance plans, Medigap plans and Medicare+Choice plans. Pharmacy Plus is designed to work effectively with other Medicare pharmacy options.

The coordination and support can be:

- Payments made to private carriers or to enrollees made in lieu of direct coverage of pharmaceuticals under the Pharmacy Plus program; and/or
- In the form of providing wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of the Pharmacy Plus benefit coverage.

In this demonstration, the following approaches will apply (check all items that apply – Also, See Section V.F.1.):

1. _____ Subsidies/cost sharing assistance for private health insurance coverage will be provided under the demonstration, and is clarified in the submitted budget neutrality information. The process for providing the subsidy will be described in the operational protocol and CMS approval of the payment methodology and amount will be requested. Subsidies/incentives will be provided for enrollees to maintain coverage of the following:

   a. _____ Private health insurance coverage (describe):
   b. _____ Medigap (describe):
   c. _____ Medicare-endorsed pharmacy discount cards. The demonstration includes financial contribution towards the drugs purchased using the card (describe coordination with the card and contribution to the purchase);
   d. _____ other (describe):

2. __X__ Pharmacy coverage will be provided to enhance other sources of pharmacy coverage, such as state programs, Medicare+Choice and private sources of coverage in a wraparound fashion in order to encourage participation in existing public and private sources of care (describe): **See F1**

3. _____ Other (describe):

4. _____Third Party Liability will be collected in the demonstration in the following manner (describe):

5. __X__ Third Party Liability will not be collected in the demonstration because:
   a. _____ individuals with other pharmacy coverage are excluded;
   b. __X__ other (describe): **The demonstration will require providers to identify and bill other insurance (Medicare+Choice and Medigap) ahead of Medicaid. Medicare will be billed ahead of EPIC Ex for any covered drugs. The state**

reserves the right to utilize resources of its TPL program to check for the availability of other insurance and to disenroll anyone identified as having other private coverage. The department will NOT utilize pay and chase tactics for this program.

6. _____ Coordination with other sources of coverage is not part of this demonstration because: _____.

I. Primary care coverage and related medical management (check all that apply)

The demonstration includes a mechanism to ensure that demonstration enrollees have access to primary care health services that will assist with medical management related to pharmacy products prescribed. These aspects of the demonstration will be implemented as follows:

1. __X__ Demonstration enrollees who have a source of coverage for primary care (for example, Medicare coverage) will use their primary care providers to coordinate the pharmacy benefit (describe): **The program will use ProDUR and RetroDUR to coordinate care between primary care physicians and the pharmacy benefit.**

2. __X__ Demonstration enrollees who do not have a source of primary care coverage will receive primary care services through the demonstration as follows:
   a. _____ A primary care benefit the same as that in Medicaid will be provided (describe):
   b. _____ A limited primary care benefit of _____ number of visits per _____,which entail the following services will be provided by _____ practitioners: _____;
   c. __X__ Primary care access will be ensured by connecting clients to primary care sources for care in the community (e.g., Federally qualified health centers/rural health clinics, Ryan White providers, Indian Health Services facilities, Veterans' Affairs clinics, etc.) If the above is checked, the following must be checked and completed:
      i. __X__ state to work with Primary Care Associations to facilitate access to services**; DCH will seek the assistance of primary care and other medical professional associations to engage in a public/private partnership that will facilitate effective case management and help ensure access for enrollees to primary care services.**
      ii. _____ geographic breakdown of FQHC services provided that demonstrates adequate capacity to serve the demonstration population;
      iii. __X__ pharmacy and state written materials for demonstration participants include names, locations, and phone numbers of community sources of primary care;
      iv. _____oral counseling by pharmacists to include information on accessing

primary care;
v. _____ Other (describe)

3. __X__ Other (describe): **The demonstration will use local health departments to provide assistance in finding a primary care provider.**

J. Premiums and cost sharing information (check all that apply)

Flexibility to include cost sharing, similar to that found in employer sponsored private health insurance coverage, is an important feature of the Pharmacy Plus Demonstration. Enrollee cost sharing can be in the form of annual or monthly premium assessments, per-prescription copayment requirements, coinsurance, deductibles, and coverage limits. Cost sharing helps the state to operate a budget neutral program and encourages personal responsibility and involvement of enrollees in their health care. States may require that cost sharing be met by demonstration participants (i.e., those in the expansion population) in order to receive benefits under the program. Cost sharing may be used to reduce program costs by requiring enrollee payments. To encourage the use of generic drugs and to discourage the use of costly drugs for which there are lower cost alternatives, Pharmacy Plus encourages states to use a three-tier system of copayments. Cost sharing models used in Pharmacy Plus may be designed to protect people with most severe illnesses or disabilities by offering "stop-loss" protection against the cumulative impact of copayments and deductibles

1. __X__ The proposed program will include enrollee cost sharing (enrollment fees, premiums, copayments, coinsurance, deductibles, etc.):

   a. __X__ Enrollment fees will be required and are _$25_ every enrollment period of _12_ months. If the fees vary according to individual FPL, specify below (describe):
   b. _____ Premiums will be required:
      i. ____ Premiums are tiered or charged according to a sliding fee schedule that is ____ attached or ____ described below:
      ii. ____ Premiums are fixed in the amount of $ _____ per person on a _____ monthly basis, _____ annual basis, or _____ other (described):

      iii. ____ Other (describe):
   c. _X _ Copayments and Coinsurance:
      i. ____ three-tiered copayment system (describe):
      ii. in the amount of _____ per prescription; or
      ii. ____ Enrollees will have different co-payments for single source, branded multi-source, and generic drugs, according to the following schedule (describe):
      iii. Brand name: $____ per prescription or ____ percent of the cost;
      iv. Branded multi-source: $____ per prescription or ____ percent of the cost;
      v. Generic: $____ per prescription or ____ percent of the cost.

   d. _____ Deductibles (describe):

e. __X__ Cost sharing requirements will vary with utilization (i.e.,premiums, copayments, and coinsurance)
   i. _____ Cost sharing amounts/requirements will decrease as individuals use more services (describe):
   ii. _____ Cost sharing amounts/requirements will increase as individuals use more services (describe):
   iii. __X___ Other (describe): **The program will employ a cost sharing formula mandated in state legislation that governs operation of the EPIC program. This formula uses a sliding scale based on total annual household income to establish a cap on how much a beneficiary is required to pay during each month. For persons at or below 100% of the Federal Poverty Level, the cap amounts to 1/12th of 1% of annual household income. For persons whose income is over 100% but not more than 125% of the Federal Poverty Level, the cap is 1/12th of 2% of annual household income. For persons whose income is over 125% but not more than 150% of the Federal Poverty Level, the cap is 1/12th of 3% of annual household income. For persons whose income is over 150% but not more than 175% of the Federal Poverty Level, the cap is 1/12th of 4% of annual household income. For persons whose income is over 175% but not more than 200% of the Federal Poverty Level, the cap is 1/12th of 5% of annual household income.**

   Coinsurance amounts equal to 20% of the cost are imposed on the beneficiary up to the cap for any given month. Enrollees cannot be charged more than 20% of the cost of a single prescription unless a brand name is purchased when a generic equivalent is available. In this case, the program will require the assessment of an additional $15 co-payment. These additional co-payments do not count towards a beneficiary's monthly cap. Unused co-pay obligations carry forward to the next month until the end of the benefit year. (The co-pay obligation aggregates to a benefit year obligation.)

2. _____ The proposed program will not include enrollee cost sharing that differs from that in the Medicaid state plan.

3. _____ The proposed program will include enrollee cost sharing stop-loss protections (describe):

4. _____ Other (describe):

K. The demonstration will deliver services in the following manner (check all that apply)

1. _____ Services will be delivered through private health insurance coverage.

2. __X__ Services will be delivered fee-for-service through this demonstration.

3. _____ Services will be delivered through a system other than fee-for-service through this demonstration (describe):

4. __X__ Services will be delivered through this demonstration using the same network of providers that deliver comparable services to Medicaid beneficiaries.

5. _____ Services will be delivered through this demonstration using a subset of providers that deliver services to Medicaid beneficiaries.

6. _____ Services will not be delivered by providers that serve Medicaid beneficiaries (describe how providers will be selected):

7. _____ Other (describe):

V. BUDGET NEUTRALITY

The Federal costs of services provided during the demonstration will be no more than 100 percent of the expected costs of providing Medicaid services under current law without the demonstration. A new population that would otherwise not be eligible for Medicaid will be able to obtain prescription drugs paid for by Medicaid. While the demonstration includes individuals who are not otherwise eligible for full Medicaid coverage, this new population could become eligible for full Medicaid coverage over the life of the demonstration through deterioration in their health status and reduced income due to high medical expenses. Federal payments will be provided for the Pharmacy Plus costs incurred for the demonstration population to the extent that Federal Medicaid payments to the state do not exceed what would otherwise be paid.

The groups subject to budget neutrality - called the impacted population - are those expected to generate savings for the state because participants in Pharmacy Plus will incur less costs and remain healthier, thereby creating a delay in the need for full benefit Medicaid, in effect, be diverted from becoming eligible for full Medicaid eligibility. While the expenditures for these groups are included in budget neutrality, the benefits of the existing Medicaid eligibility groups are not to be altered. Cutbacks in eligibility for existing Medicaid eligibility groups covered under the state's Medicaid Plan cannot be used as a source of savings for purposes of meeting budget neutrality. Savings that do not reduce benefits or limit eligibility but are achieved through better management of pharmacy services to existing Medicaid populations may be considered in the budget neutrality calculations. States should include only direct Medicaid costs and savings in their budget neutrality calculations.

The Terms and Conditions of Approval will specify that demonstrations must be in compliance with Federal law and regulation related to sources and uses of Medicaid financing. In its budget neutrality calculations, the state should be able to demonstrate the impact of any recent changes to Medicaid law and regulation in its without-waiver and with-waiver calculations. For example, a state with an approved Upper Payment Limit plan, entitled to a transition period, under regulation, must demonstrate how the excess payments made under the UPL plan will be phased out during the waiver.

The Terms and Conditions of Approval will specify the aggregate financial ceiling for future expenditures for which Federal financial participation (FFP) will be available. Under the aggregate ceiling methodology the state and Federal authorities must reach agreement prior to demonstration approval on cost and eligibility trend rates. The trend rates will then be in place in the budget ceiling during the demonstration.

The attached budget shell relies upon a credible methodology that estimates a budget neutral program. When a Pharmacy Plus demonstration entirely or partially subsumes a state-only funded pharmacy program, the state must provide documentation as to how Medicaid expenditures will be reduced under the demonstration (compared to the "without demonstration" levels) and how budget neutrality will be achieved. The attached budget shell __X__ was used in the development of the budget neutrality ceiling.

A. **Impacted budget neutrality population.** Table V.1 identifies the Medicaid population groups that are included in the budget neutrality calculation (i.e., the impacted population).

Table V.1 (check all groups that apply):				
Population	All (1)	Institutionalized (2)	Community Dwelling (3)	Other (described): (4)
Aged	X			
Blind/Disabled Adults				X
Blind/Disabled non-Adults				

Blind and disabled adults aged 65 and older are included in the budget neutrality analysis.

B. **Costs**. The state estimates the services cost of this program will be $_334,524,605_ over its _5_ year demonstration period.

Refer to attached Excel spreadsheet for details.

VI. EXPENDITURE AUTHORITY

The following authority is needed for this demonstration under costs not otherwise matchable (item is checked to verify the request):

A. __X__ Section 1115(a)(1) authority of the Social Security Act is requested to enable the state to restrict freedom of choice of provider through a method such as pharmacy benefit management.

B. __X__ Section 1115(a)(2) authority of the Social Security Act is requested for the following expenditures to be made under the _EPIC Ex_ demonstration (which are not otherwise included as expenditures under section 1903) for the period of the demonstration to be regarded as expenditures under the Title XIX program.

> Expenditures for extending pharmacy benefits for _adult_ individuals _over age 65_ at or below _200_ percent of the Federal poverty level (FPL) who are Medicare eligible, meet all applicable Medicaid non-financial eligibility criteria and are not otherwise Medicaid eligible under the state plan except for Medicaid coverage of Medicare premiums or cost sharing.

In addition, the following will <u>not</u> be applicable in this demonstration:

- *Premiums and Cost Sharing under Section 1916*: To permit fixed premiums, and cost sharing that is more than nominal, to be imposed on and collected from demonstration participants.

- *Amount Duration and Scope of Services under Section 1902(a)(1O)(B):* To permit the state to offer demonstration participants benefits that are not equal in amount, duration and scope to traditional Medicaid beneficiaries.

- *Retroactive Eligibility under Section 1902(a)(34):* To permit the state not to offer demonstration participants retroactive eligibility.

- *Premiums under Section 1902(a)(14):* To permit the state to impose on and collect premiums from demonstration participants in excess of those that would be permitted under section 1916.

VII. EVALUATION

The purpose of Pharmacy Plus is to expand coverage of a prescription drug benefit to Medicare low-income aged and disabled, and, by so doing, to divert or defer entry by these individuals into the Medicaid program. Budget neutrality is a feature of these demonstrations and is designed to track the overall cost and savings of the program. However, it is important to evaluate these demonstrations in other than budgetary terms. To understand how effective the program is for individuals, provide a description below of the state context of the program, the goals for the program, and how the program's success will be evaluated. In addition, CMS intends to conduct an independent evaluation of several of the Pharmacy Plus demonstration projects.

Included as an Attachment to the Application are the following:

A. __X__ Current State Context. Provide an assessment of the current pharmacy coverage status of individuals in the state which includes summary information of individuals whose incomes are at or below 200 percent FPL who:

1. __X__ do not have private insurance or other coverage of pharmaceuticals;

2. __X__ are in the state only funded pharmacy program;

B. __X__ The state's goal for increasing pharmacy coverage to the population targeted by the demonstration, including:

1. __X__ the state's demonstration hypothesis;
2. __X__ the state's execution of the hypotheses via the demonstration project operation.

VIII. ADDITIONAL REQUIREMENTS

In addition to the above requirements, the state agrees to the Pharmacy Plus Model Special Terms and Conditions (STCs) of Approval, and agrees to prepare the Operational Protocol document as described in the Model STCs. During CMS's review and consideration of this demonstration request, using the Model STCs, we will work with CMS to develop STCs that are specific to this request that would become part of the approval of demonstration authority.

This demonstration proposal is submitted to CMS on ___-___-___.

_____ _____

Date Name of Authorizing Official, Typed

_____

Name of Authorizing Official, Signed

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 1

Public Notice (Assurance D Description)

Provide a description of the public notice process for Pharmacy Plus, including varying activities and stakeholder groups included in each:

The public notice process for the Pharmacy Plus program will adhere to the process used for public notice by the Michigan Medicaid program for Medicaid bulletins. Accordingly, public notice requirements published in the Federal Register on September 27, 1994 will be followed. The Medicaid program provides notice to 12 newspapers published in markets throughout the state. A brief description of the Pharmacy Plus waiver proposal will be printed in the public notice with direction to the Department of Community Health website where the waiver will be posted for the public to review in its entirety. The public will have 30 days in which to provide written comment via a link on the website or on paper. The mailing address to which comments may be directed will be published in the newspaper notice as well as on the website.

The Michigan Medicaid program will provide opportunity for Tribal Consultation on the Pharmacy Plus demonstration waiver. A letter informing the Michigan Tribes of the Pharmacy Plus waiver submission will be mailed to the Tribes on the day the waiver is submitted to CMS. Identical letters will be mailed to Inter-Tribal Council and the urban Indian organizations. The letter directs the Tribes to the MDCH web site and will offer 30 days in which to provide comment as required by the State Medicaid Director Letter (SMDL) #01-024. In its letter to the Tribes, the Department will also extend the opportunity to schedule a face-to-face meeting or a conference call to discuss the components of the waiver and to accept comment.

In addition, notification of the Pharmacy Plus demonstration will be provided to the Department of Community Health's Office of Services to the Aging for distribution to its network of providers and consumers. The Michigan Association of Area Agencies on Aging will also be provided with an opportunity to comment through the public notice process. All of the Senior EPIC Centers that work with the existing EPIC program will be informed of the waiver submission through an EPIC Advisory notice that is used to inform the centers of any program changes or provide clarification to policy.

PHARMACY PLUS
A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 2

DEFINITIONS

Budget Neutrality –The policy for Section 1115 demonstrations under which the Federal costs of services provided during the demonstration will be no more than the expected Federal cost to provide Medicaid services without the demonstration.

Budget Neutrality Ceiling –An expenditure limit, negotiated between the state and CMS, placed on the amount of FFP available to a state under the demonstration. The expenditure limit for Pharmacy Plus waivers is calculated using the aggregate method. The aggregate expenditure limit is calculated as a fixed amount that does not vary based upon enrollment changes in the state.

Private Health Insurance - Group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Services Act.

Expansion population - Individuals eligible for benefits under the state Pharmacy Plus demonstration program who are not enrolled in the regular Medicaid program.

Traditional Medicaid benefit – The Medicaid benefit package available to individuals who are eligible under the state plan for Medicaid without the Pharmacy Plus waiver.

Impacted population - The Medicaid eligibility group or groups whose Medicaid costs are included in the budget neutrality cap. Under Pharmacy Plus, the state is expected to achieve savings from this group because of the diversion from the regular Medicaid program of a proportion of the expansion population.

Enrollee Cost Sharing – Premium charges, enrollment fees, deductibles, coinsurance, copayments or other similar fees that the Pharmacy Plus enrollee is responsable for paying. Cost sharing for Pharmacy Plus enrollees can deviate from requirements in Medicaid and can be used to reduce program costs by requiring participant payments, encouraging the use of non-brand drugs, and can vary to moderate out of pocket burdens for high utilizers.

Enrollment Ceiling -- A number limit on demonstration program enrollment. States may use an enrollment ceiling to limit the numbers of individuals enrolled in the demonstration so that financial risk for demonstration costs is minimized. States may not enact an enrollment ceiling for the non-demonstration Medicaid program.

Drug Rebates - The quarterly payments made by the pharmaceutical manufacturer to the state Medicaid agency, as calculated in accordance with section 1927 of the Social Security Act and

the provisions of the agreement between the manufacturer and the Secretary. States can receive rebates for pharmaceutical products in Pharmacy Plus as long as a state payment is made for the drug.

Wraparound Coverage - Pharmacy Plus coverage of services not covered under a beneficiary's private health insurance. Examples of wraparound coverage include a Pharmacy Plus program paying for drugs not covered by private insurance, a Pharmacy Plus program covering an amount of drugs in excess of that covered by private insurance (for example, if the private insurance coverage includes three prescriptions per month, Pharmacy Plus could pay for additional prescriptions); and Pharmacy Plus coverage when a private insurance financial benefit is exceeded.

Terms and Conditions of Approval - A document produced by CMS which provides conditions which states must follow in order to receive approval of their Pharmacy Plus waiver.

Operational Protocol - A stand-alone document that reflects the operating policies and administrative guidelines of the Pharmacy Plus waiver.

Prior Authorization – Requiring approval of the drug before it is dispensed as defined in 1927(k)(6) of the Act.

Formulary or Formulary Exclusions - A list of prescription drugs developed in accordance with 1927(d)(4) of the Social Security Act.

Medicare Savings Programs - Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program. There are various benefits available to "dual eligibles" who are entitled to Medicare and are eligible for some type of Medicaid benefit.

DRAFT

Attachment 3

Michigan
Pharmacy Plus Waiver
EPIC Ex Program

Supplemental Information

Introduction

Michigan is seeking approval for a federal Medicaid Pharmacy Plus wavier to provide prescription drug coverage for people age 65 and older with income at or below 200% of the federal poverty level. Known as EPIC Ex, this demonstration will draw federal matching funds to expand the existing Elder Prescription Insurance Coverage (EPIC) program that is funded entirely with state dollars.

In order to qualify for enrollment, a person can have no other type of prescription drug coverage except for supplemental Medicare. In addition, they may not have a pharmacy benefit under regular Medicaid and must be non-institutionalized residents of the state for at least three months prior to applying for benefits.

Enrollees will pay an annual $25 enrollment fee, and will be responsible for 20% of the cost of each prescription, up to a capped amount per month that is based on the amount of household income. An additional co-payment is required if a brand name drug is purchased when an equivalent generic version is available. EPIC Ex covers most prescription drugs plus insulin and syringes for diabetics. Wrap-around coverage will be provided for people with a limited drug benefit under a Medigap policy. The Michigan Pharmaceutical Products List will apply.

The existing EPIC program covers approximately 15,000 individuals. With the federal match that is available under this waiver, the program will be expanded to cover as many as 42,000 people. Because it is likely that demand will exceed available slots, priority will be given to people with income below 150% of poverty. Over the life of the waiver, program size will depend on the availability of state dollars to serve as state match.

The following information is provided to supplement and support what is presented in the standard Pharmacy Plus waiver template. The anticipated begin date is July 1 of 2003, and the waiver will cover five years, with an ending date of June 30, 2008. Each demonstration year will therefore run from July 1 through June 30. This schedule is subject to change if there are any delays in implementation.

State Context

The purpose of Michigan's Elder Prescription Insurance Coverage Expansion (EPIC Ex) program is to improve the health of as many as 42,000 low-income persons age 65 and older by providing them with a pharmacy benefit that would not otherwise be available. As a result of their

improved health status, many of these people will be diverted from enrollment in regular Medicaid. Money saved as a result of this diversion will be used to pay for EPIC Ex.

In 2001, it is estimated that Michigan's population contained more than 277,000 people age 65 and older with income between 100 and 200% of the federal poverty level. While most of these people are likely to have basic health coverage through Medicare, a large number do not have a suitable pharmacy benefit. For people age 65 and older whose income is below 100% of the federal poverty level and who meet other eligibility criteria, a pharmacy benefit is provided through regular Medicaid.

Among all Medicare beneficiaries in the United States, approximately half are believed to have supplemental insurance with a standard pharmacy benefit. Of the remainder, approximately 2/3 have no drug coverage while the other third have a limited benefit. Supplemental policies such as Medigap can be purchased for services such as prescription drugs that are not covered by Medicare, but the cost is very high, especially if a standard insurance benefit is included. Therefore, most low-income elderly cannot afford such coverage, and it is likely that the percentage of people who lack an adequate prescription drug benefit is higher for low-income elderly than for the entire universe of Medicare enrollees.

To the extent that numbers reflecting the country as a whole can be applied to Michigan, at least 139,000 people between 100 and 200% of the federal poverty level have either inadequate pharmacy coverage, or no coverage at all. It is this group that Michigan will target with its Pharmacy Plus waiver.

Goals for the Program

An emerging body of research suggests that access to drugs, including newer and more expensive products, will reduce overall costs through improved personal health and a reduced need for more expensive health care services. With comprehensive prescription drug coverage such as that which will be provided through Michigan's Pharmacy Plus waiver, low-income seniors whose income and/or assets are too high to quality for Medicaid will have their prescription needs met, thereby increasing the likelihood that their health will be maintained. As a result, the erosion of personal resources will be prevented and the likelihood that they will need to enroll in regular Medicaid will be reduced.

By providing coverage for up to 42,000 low-income elderly citizens, Michigan expects to divert enough people from the Medicaid program to reduce average monthly enrollment by approximately 3,000. Savings will accrue by reducing the need for more intensive services such as nursing home care, inpatient hospitalization and other expensive services that are covered by Medicaid.

In addition to savings realized as a result of diversion from Medicaid enrollment, EPIC Ex will achieve federal budget neutrality by utilizing savings achieved through the application of its preferred drug list to all categories of Medicaid enrollees whose age is less than 65 years. The Michigan Pharmaceutical Products List (MPPL) will reduce the cost of prescription drugs for all

Medicaid beneficiaries, including the expansion group to be enrolled in EPIC Ex. For purposes of calculating federal budget neutrality, only those savings that can be attributed to enrollees under age 65 are included so as to avoid possible problems related to double counting. The amount of savings achieved through the MPPL for the regular Medicaid population under age 65 will be added to savings achieved through diversion to establish the aggregate cap, or portion of costs incurred by EPIC Ex that will be eligible for federal match.

Existing State-Funded Pharmacy Program

Michigan's existing pharmacy program for low-income elderly will be subsumed within Pharmacy Plus, thereby allowing the state to significantly increase the number of enrollees. The Elder Prescription Insurance Coverage (EPIC) program was implemented in October of 2001 to assist the state's low-income seniors with the cost of their prescription drugs. EPIC replaced the Michigan Emergency Pharmaceutical Program for Seniors (MEPPS) and the Michigan Senior Prescription Drug Tax Credit program that provided limited prescription assistance to seniors. Individuals who participated in these former programs were given the first opportunity to enroll in EPIC.

To qualify for EPIC, individuals must have a gross household income that is equal to or less than 200 percent of the federal poverty level (FPL). Applicants must be non-institutionalized residents of the state for at least three months prior to applying for benefits, and they are not eligible if they have any other type of prescription drug insurance coverage. EPIC has a non-refundable $25 application-processing fee that is required of every applicant. The benefit period for EPIC is one year from the date of enrollment and must be renewed annually. Except for the emergency component, enrollment is not currently open for new participants.

EPIC covers most prescription drugs plus insulin and syringes for diabetics. The State of Michigan has a list of drugs from which it prefers that physicians prescribe because these drugs have been proven to be both therapeutically sound and cost effective. Drugs that have not been chosen for this list may require prior authorization before they are paid for by EPIC.

All EPIC enrollees are responsible for co-payments. The co-payment amounts are based on the participant's total annual household income. At the time of enrollment, participants are notified of their maximum annual co-payment. This amount is divided into twelfths so that a monthly amount must be met. If the co-payment is not met in that month, the co-payment is cumulative, and any remainder is added to the following month's co-payment. The co-payment does not carry over from one benefit year to another. No co-payment for a single prescription may exceed 20 percent of the total cost of the drug.

EPIC encourages the use of generic drugs. If a brand name drug is prescribed and dispensed when a generically equivalent drug is available, a $15 co-payment in addition to the monthly out-of-pocket share will be charged.

Routine enrollment in EPIC is currently closed. However, EPIC has an emergency enrollment component that is available for individuals who meet the qualifying criteria. Emergency enrollment requires that individuals have household income at 150 percent or less of the FPL and

a true medical emergency must exist. The emergency enrollment period is 45 days and the emergency benefit is available up to two times a year.

Development of the Program Budget

Michigan has developed a budget for its proposed Pharmacy Plus waiver with a plan to achieve federal budget neutrality based on a methodology that is fundamentally consistent with the approach sanctioned by CMS. This methodology is reflected in the attached budget shell spreadsheets that have been adapted from forms that were developed by CMS.

Michigan's methodology is described in detail below, along with an explanation of components that deviate from the model present by CMS. Critical factors that must be considered in developing a financing plan include (1) maintaining federal budget neutrality and (2) recognizing limitations on the availability of state funds to serve as local match over the five-year life of the proposed program.

There will be two components to determining the amount of federal match that is available to support Pharmacy Plus, and likewise for establishing an aggregate funding cap for this program. The first component involves diversion from full Medicaid coverage of people age 65 and older as a result of having a pharmacy benefit. This approach has been embraced by CMS through its approval of pharmacy waivers in other states and is reflected in a template developed by CMS for states to use in developing their own waiver program. A second component allows consideration of savings that result from private sector administrative models such as the Michigan Pharmaceutical Products List.

1. Diversion

Medicaid eligible months and paid claims data were obtained for the ABAD (Aged, Blind and Disabled) over age 65 and OAA (Old Age Assistance) programs covering fiscal years 1998 through 2002. Costs related specifically to pharmacy were subtracted to reflect federal drug rebates. Mental health costs based on a rate per member month were added. The value of savings which can be attributed to the Michigan Pharmaceutical Products List, which would otherwise be reflected in regular paid claims data, were also added back into total paid claims for fiscal year 2002 in order to accurately trend "without waiver" costs. In this case, "without waiver" also assumes that the MPPL does not exist.

Using these data, an average aggregate cost per member per month (pmpm) by fiscal year for all Medicaid coverages was calculated. Consistent with the methodology sanctioned by CMS, eligible months and the cost per member per month were trended over the five-year life of the waiver. Trending of the cost per member month deviates from the CMS template by incorporating a "sum of years digits" calculation. This is done to assign greater value to the most recent budget years, the assumption being that more recent years serve as a more accurate indicator of future activity. Trended member months are then multiplied by trended costs per member per month to arrive at an estimated annual cost for serving persons over 65 years of age through the five-year life of the waiver beginning on July 1, 2003. An adjustment has been made to the projected

pmpm cost for the first year of the waiver to account for additional funding that will be realized from a quality assurance assessment on nursing homes. The impact of this assessment is then trended forward as part of total paid claims.

Diversion factors are applied to all persons who are age 65 and older in the OAA and ABAD aid categories at 2 percent for the first two years and then 3 percent for the remaining three years of the waiver. Michigan has opted to use diversion factors that are more conservative than those used by other states.

2. *Michigan Pharmaceutical Products List*

A second component of federal budget neutrality involves a calculation of savings from the Michigan Pharmaceutical Products List (MPPL). According to language within the CMS waiver template, states are allowed to apply benefits achieved for the entire Medicaid population resulting from administrative initiatives such as the MPPL to revenue neutrality calculations for the Pharmacy Plus waiver. States are encouraged to use private-sector benefit management approaches such as pharmacy benefit managers, preferred drug lists, prior authorization, pharmacist consultation, provider education, disease state management, and variable enrollee cost sharing in order to more efficiently and effectively manage pharmaceutical costs and ensure that spending stays within the Federal budget neutrality cap.

Michigan intends to count savings garnered through the MPPL. However, to avoid potential problems related to the possible double counting of savings, only savings attributed to persons under age 65 will be used. Savings from the MPPL are already incorporated into "with waiver" costs for the age 65 and older group as a result of trending that was done for the diversion component.

MPPL savings are based only on Michigan's fee for service Medicaid program. Paid claims for pharmacy and eligible months are broken out into categories that are appropriate for establishing trends. These include aid categories (TANF L, TANF non-L, OAA and ABAD), age (65 years and older, under 65) and Medicare status (dual and non-dual). Data have been pulled by month dating back to fiscal year 1998. As with the diversion component described above that addresses total paid claims for beneficiaries over age 65, trends will be developed both for per member per month costs and for eligible months.

Using statistical trend modeling, eligible months and pharmacy paid claims were trended by month through fiscal year 2003. Per member per month costs were then multiplied by eligible months to develop an estimate of paid claims by month for fiscal years 1998 through 2002 (actual experience) and 2003 trended by month. These projections were then aggregated into fiscal years, thus making it possible to calculate an estimate of eligible months and a per member per month cost by fiscal year.

Eligible months and pmpm costs were then trended forward by fiscal year through the five-year life of the waiver. It should be noted that eligible months for the under age 65 Medicaid population used to calculate savings from the MPPL were held steady through the life of the

waiver in anticipation of factors that could not be addressed by available trending tools. As with the diversion component, trended eligible months were multiplied by trended cost per member per month to calculate an estimate of the total pharmacy cost by year through the five-year life of the waiver. This method was applied to both "with MPPL" and "without MPPL" scenarios. Once adjustments were made to account for rebates under each scenario, savings that are expected to result both from diversion of persons over age 65 and the MPPL were added together to establish the amount of money available for federal match under the waiver.

3. *Pharmacy Plus Program Costs*

To complete an analysis of "with waiver" costs, the cost of providing a pharmacy benefit to the expansion population (persons served under the waiver) was developed. Basic assumptions are as follows:

- Pharmacy Plus will cover up to 42,000 average eligibles per month during the first year. That number will likely decrease through the remaining years of the waiver based on the amount of state match that is expected to be available.
- Based on experience with pharmacy paid claims (1) for persons age 65 and older who are served in the Medicaid program and (2) for persons in EPIC, it is estimated that the per member per month cost during the first year of program operation will be $122 net of rebate. From that point forward, pmpm costs were increased at a rate similar to the projected increase in costs for pharmacy services for all Medicaid beneficiaries age 65 and older.
- Eligible months are multiplied by projected pmpm costs to calculate an estimated annual cost for the Pharmacy Plus program.

"With waiver" costs equal (1) costs incurred without the waiver for Medicaid beneficiaries who are age 65 and older (2) minus costs saved by diversion resulting from a pharmacy benefit (3) plus the estimated cost of the Pharmacy Plus program. The aggregate payment limit that is to be used for determining allowable federal match includes "without waiver" costs for the age 65 and older Medicaid population plus savings for the under age 65 Medicaid population attributable to the Michigan Pharmaceutical Products List.

Michigan's Pharmaceutical Best Practices Initiative

The Michigan Pharmaceutical Best Practices Initiative (MPBPI) began with the implementation of the Michigan Pharmaceutical Products List (MPPL) in February 2002. It is designed to cover all pharmacy programs funded through the Department of Community Health. By establishing a clinically based model for the identification of drugs requiring prior authorization and medical justification, the initiative provides the state with a comprehensive drug management tool.

Nearly 1.5 million Michigan residents receive pharmacy benefits through the Michigan Department of Community Health. They include persons covered through Medicaid Fee-for Service, Medicaid HMOs, Elder Prescription Insurance Coverage Program (EPIC), Community Mental Health, MIChild (SCHIP), Children's Special Health Care Services, and Maternal

Outpatient Medical Services (MOMS).

Together, these programs account for $1.1 billion in drug expenditures annually. The fee-for-service drug expenditures alone grew by 100% over a four-year period. As a result, Medicaid expenditures have become the largest single driving force in the state budget. The Pharmaceutical Best Practices Initiative represents an attempt to maintain benefits while holding the line on costs.

The establishment of a single, comprehensive Pharmaceutical Products List allows the state to utilize purchasing concepts from the private sector. Prior Authorization programs have been in effect for a majority of private insurance companies for years. The Michigan Medicaid program, especially with the fee-for-service population, had historically done very little in the way of prior authorization or other types of drug management. However, prior authorization of prescriptions is a permissible restriction under Section 1927(d)(1) of the Social Security Act, which says, "A State may subject to prior authorization a covered outpatient drug."

The cornerstone of the MPBPI is the establishment of the Pharmacy and Therapeutics (P & T) Committee. This group selects therapeutic drug classes for review and performs clinical analysis on the individual drugs within that class. A "reference drug" is identified, based on the characteristics of the therapeutic class. The committee then determines if any of the drugs in the class require its patients to be "grandfathered" or exempted from the prior authorization requirements. For example, many of the anti-depressant and anti-psychotic drugs are grandfathered, due to the unique benefits of these drugs for the patients who use them.

After the clinical preference of a drug has been determined, a price equity evaluation is done to determine the amount of a possible supplemental rebate necessary to bring a higher priced drug in line for preferred drug status. The Preferred Drug List is therefore comprised of the reference drugs selected by the P & T Committee, drugs priced lower than the reference drugs, and drugs whose price is offset by a supplemental rebate. It should be noted that the best practices initiative is not allowed to accept "gimmicky" alternatives such as pill splitting or unproven disease management programs. Non-preferred drugs require prior authorization and medical justification before they can be dispensed through the program.

To date, the Michigan P & T Committee has reviewed some 40 therapeutic classes that are part of the MPPL. These drugs represent 75% of the Medicaid pharmacy expenditure. Since the implementation of the MPPL, the average cost per claim has been reduced by $3.39.